FA-001-L (3-03)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Family Assistance Administration

LANGUAGE NEEDS

CASE NAME *(Last, First, M.I.)*	CASE NO.	DATE

I. YOUR RIGHT TO SERVICES IN YOUR LANGUAGE

You have a right to a free interpreter when you apply for or receive Cash Assistance, Food Stamps or AHCCCS Medical Assistance. You also have the right to ask DES to send forms and letters to you in your language. These services must be provided to you within a reasonable time frame.

II. WHAT LANGUAGE DO YOU SPEAK? *(Please check only one box.)*

☐ I speak English and do not need special language services.
☐ I speak the language checked below:

☐ Albanian	☐ Greek	☐ Maithili	☐ Spanish
☐ Amharic	☐ Gujarati	☐ Marathi	☐ Sudanese
☐ Apache	☐ Havasupai	☐ Maricopa	☐ Tagalog
☐ Arabic	☐ Hindi – Indian (India)	☐ Mien	☐ Tamil
☐ Bengali	☐ Hmong	☐ Mohave	☐ Tegulu
☐ Bosnian	☐ Hopi	☐ Mon-Khmer	☐ Tewa
☐ Cambodian	☐ Hualapai	☐ Navajo	☐ Thai
☐ Chinese/Cantonese	☐ Hungarian	☐ Paiute	☐ Tohono O'Odham
☐ Chinese/Mandarin	☐ Indonesian	☐ Pima	☐ Turkish
☐ Cocopah	☐ Italian	☐ Polish	☐ Urdu
☐ Croatian	☐ Japanese	☐ Portuguese	☐ Ute
☐ Dinka	☐ Kannada	☐ Punjabi	☐ Vietnamese
☐ Farsi	☐ Kashmiri	☐ Quechen	☐ Yaqui
☐ Filipino	☐ Khmer	☐ Romanian	☐ Yavapai
☐ French	☐ Korean	☐ Russian	☐ Yiddish
☐ French Creole	☐ Laotian	☐ Serbian	☐ Yoruba
☐ German	☐ Lithuanian	☐ Somali	☐ Zuni

☐ Other *(Specify)* _____

III. HOW WOULD YOU LIKE FOR US TO COMMUNICATE WITH YOU? *(Please check only one box.)*

☐ I want DES to send me forms and letters in English.
☐ I want DES to send me forms and letters to me in the language checked above. If DES cannot do this, I want DES to orally translate the forms and letters to me.
☐ I need all forms and letters orally translated to me because I do not read well enough to understand them.

CERIFICATION OF LANGUAGE

The person identified above could not complete this form on his/her own. I determined this person's language by the following method:

☐ Bilingual staff _____
(Name/Worker PCN)

☐ Interpretation line _____
(Service Used)

☐ Other _____
(Type of Method)

DES WORKER'S NAME *(Please Print or Type)*	DES WORKER'S NAME SIGNATURE	WORKER'S PCN	DATE

Equal Opportunity Employer/Program ♦ Under the Americans with Disabilities Act (ADA), the Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service, or activity. For example, this means that if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. This document is available in alternative formats by contacting your local office manager.